MDR Tracking Number: M5-04-1155-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-23-03.

Services rendered prior to 12-23-02 were submitted untimely per above referenced rule and will not be considered in this decision.

The IRO reviewed office visits, joint mobilization, manual traction, continuous passive motion, therapeutic exercises, miscellaneous supplies, aquatic therapy, electric stimulation, prolonged services, myofascial release and physical therapy services rendered from 12-23-02 through 3-10-03 that were denied based upon "V".

The IRO concluded that office visits with manipulation on 1-21-03 and 2-18-03, were medically necessary. (The IRO also concluded that office visits and reports rendered on 3-28-03, 4-18-03 and 6-21-03 were medically necessary that were not denied based upon "V"). The IRO concluded that all other services were not medically necessary.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(r)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	MAR$ (Maximum Allowable Reimbursement)	Medically Necessary
1-21-03 2-18-03	99213MP	$50.00	$48.00	$48.00 X 2 dates = $96.00

On this basis, the total amount recommended for reimbursement ($96.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 2, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services I

identified above. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-30-02 1-2-03	99080-73	$15.00	$0.00	F	$15.00	Rule 129.5(d)	MAR for work status report of $15.00 is recommended.
1-23-03 4-18-03	99080 132 pgs. 159 pgs.	$99.00 $119.25	$0.00	F	$0.50 / pg	Rule 133.106 (f)(3)	MAR for copies of records is $.50 per page. Therefore, reimbursement of 132 pgs = $66.00 + 159 pgs = $79.50 for a total of $145.50 is recommended.
1-14-03 1-16-03 3-28-03 4-19-03 6-21-03	99090	$110.00	$0.00	F	$108.00	CPT Code Descriptor	MAR is $108.00 per MFG, reimbursement of 5 X $108.00 = $540.00 is recommended.
2-27-03	99455RP	$50.00	$0.00	No EOB	$50.00	CPT Code Descriptor	MAR is $50.00 per MFG, reimbursement of $50.00 is recommended.
5-12-03	99455RP	$50.00	$0.00	F	$50.00	CPT Code Descriptor	MAR is $50.00 per MFG, reimbursement of $50.00 is recommended.
1-27-03	99213MP	$50.00	$0.00	No EOB	$48.00	CPT Code Descriptor	MAR is $48.00 per MFG, reimbursement of $48.00 is recommended.
1-27-03	97122 (2)	$70.00	$0.00	NO EOB	$35.00 / 15 min	CPT Code Descriptor	MAR per MFG of $70.00 is recommended.
1-27-03	97265	$45.00	$0.00	NO EOB	$43.00	CPT Code Descriptor	MAR per MFG of $43.00 is recommended.
1-27-03	97110 (4)	$140.00	$0.00	NO EOB	$35.00 / 15 min	CPT Code Descriptor Medicine GR (I)(A)(9)(b)	MAR per MFG of $140.00 is recommended.
1-27-03	97250	$45.00	$0.00	NO EOB	$43.00	CPT Code Descriptor	MAR per MFG of $43.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of **$1144.50.**

This Decision is hereby issued this 7th day of September 2004

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 12-23-02 through 6-21-03 in this dispute.

This Order is hereby issued this 7th day of September 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 1, 2004

MDR Tracking #: M5-04-1155-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the supplied documentation, it appears that ___ sustained an injury to her wrists on ___ as a result of repetitive use. The claimant was evaluated by ___ on 10/04/2002. Plain film x-rays revealed narrowed left carpal tunnel and increased mobility in the cervical spine. Passive chiropractic therapy was started and was transitioned into active therapy. The claimant had a diagnostic ultrasound performed on 10/21/2002, which revealed carpal tunnel synovitis and swelling of the carpal ligament structures. A NCV performed on 10/21/2002 revealed a very mild left carpal tunnel syndrome. A MRI was performed on the claimant's cervical spine as well as bilateral wrists. The MRI revealed a 2 mm focal disc protrusion at C5-6 with no neurological impingement. The wrist MRI revealed minimal changes in the soft tissue, but reported moderate

loss of the peritendinous fat between the superficial and deep flexor tendons. The claimant was seen by ___ who prescribed medications. The claimant had an impairment rating performed on 01/31/2003 by ___ and it was determined that she was not at MMI. The claimant began care with ___ in the beginning of 2003 who felt that she probably had carpal tunnel and a disc protrusion at C5-6. The claimant underwent cervical epidural steroid injections. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including office visits, joint mobilization, manual traction, continuous passive motion, therapeutic exercises, misc. supplies, physical therapy treatment, aquatic therapy, electrical stimulation, prolonged services, therapy procedures and myofascial release rendered between 12/23/2002 and 03/10/2003

Decision

I agree with the treating doctor that the office visit with manipulation was necessary on 12/18/2002, 01/21/2003 and on 02/18/2003. I also agree that the medical records and reports services rendered on 03/28/2003, 04/18/2003 and on 06/21/2003 were medically necessary. I agree with the insurance company that the remainder of the therapy was not medically necessary.

Rationale/Basis for Decision

According to the documentation supplied, the claimant underwent a reasonable amount of chiropractic therapy prior to the dates in question. After 3 months post-injury, it would be necessary to change to a more aggressive therapy approach. Since the claimant continued to have pain beyond the initial 3 months of therapy, it would be necessary to refer to a proper orthopedic specialist to continue any future care. Ongoing active and passive modalities are not necessary or considered reasonable to improve the claimant's condition. If the treating doctor felt that continued active care would reduce the claimant's symptoms, then an appropriate home-based exercise protocol could be introduced. The daily notes supplied do not warrant continued ongoing therapy. The documentation that was requested is considered reasonable and required by TWCC protocols. Monthly office visits are reasonable and medically necessary in the evaluation and referral process.